Consultation Question on the draft

HSE National Integrated Care Guidance.

1. In your opinion, what are the most challenging issues in relation to timely discharge and transfer from hospital?

Please list:

There is a substantial body of evidence that shows when patients move between care providers the risk of miscommunication and unintended changes to medicines remain a significant problem. Medication errors can significantly contribute to the risk of re-hospitalization, problems with medication are a main cause or contributory factor to one in four non-elective medical admissions. Increased involvement of pharmacists, at a hospital and community level, and greater interaction across the care interface at key points in the discharge/transfer planning process could reduce these risks and associated morbidity.

The management of medicines, including education, counselling and reconciliation should fall primarily under the responsibilities of the pharmacist, as part of an involved, integrated team. The roles of the superintendent and supervising pharmacists as those in overall control of medication management should be recognised in the guidance.

As part of the discharge process, information regarding the patients' discharge needs including discharge medication, diagnosis and medication indications, must be passed on to the patients' next care setting. In order for this to be effectively achieved it is necessary that a proactive pre-admission medication history has been obtained. Information about patients' diagnosis, discharge medicines and their indications should be communicated in a way which is timely, clear, unambiguous and legible. Further emphasis on the importance of this communication between care settings may be needed in the guidance. A timely, well-structured communication would enable a more fluid movement of the patient from one care context to another, from the perspective of medicines management particularly. All this information should be passed in a uniform, standardised manner from primary to secondary care, including the GP and community pharmacist, as key members in this care pathway.

Information on diagnosis, discharge medicines and indications should be available for direct communication to the community pharmacist in order to allow the patient timely access to their medicines and services on discharge, and therefore eliminating the need for transcription of the prescription by the patients' GP, at discharge, a process which can introduce risk of error and effect the patients' ability to obtain timely access to medicines.

Further emphasis needs to be given in the guidance to the importance of the patient care plan and a patient held record of care.

Organisations should consistently monitor and audit how effectively they transfer information about medicines.

2. Does the guidance provide sufficient direction in relation to those issues?

Yes	
No	✓
Unsure	

Comments:

The pharmacist should be clearly identified in the guidance as the healthcare professional in overall control of medicines management, and there should be clear protocols and procedures in place for the discharge of this function, and the co-ordination of these services within the integrated care team.

'The transfer/discharge communication and discharge prescription contains a complete and comprehensive list of all medication the service user is to continue taking on discharge from hospital. Where possible, any pre-admission medication which was discontinued during the hospital stay is listed, outlining a brief reason for discontinuation. There is no ambiguity as to whether a medication which is absent from the list was discontinued or omitted unintentionally.'

This element of the guidance is strongly welcomed; this point may need to be more heavily weighted within the document due to its importance in reducing medication errors at the interface between hospital and community care. If possible a universal standardised form should be utilised, which details, new medicines, dose changes and discontinued medicines clearly, along with a complete list of current medicines on discharge/transfer.

3. Is the guidance easy to understand?

Yes	✓
No	
No View	

Comments:

In general yes the guidance is easy to follow, however the schematic and elaborative text do not coincide sequentially in the section on the 'Nine steps for effective discharge planning'. It would promote a more standardised process, as well as aiding readability, if standard sequence of events in the discharge chain was maintained.

4. Is the language clear and understandable?

Yes	✓
No	
No View	

Comments: Yes the language used is clear and appropriate.

5. Are there any terms in the document which should be clarified /explained?

Yes	
No	✓
No View	

If yes, please list:

6. Is the information presented in a logical sequence?

Yes	
No	✓
No View	

Comments: As previously mentioned, the schematic and elaborative text do not coincide sequentially in the section on the 'Nine steps for effective discharge planning'.

7. Is the level of detail provided adequate?

Too much	✓
Too little	✓
Just right	
No View	

Suggestions (e.g. if too little, what additional information is required?

In certain sections of the guidance further detail may aid in giving stronger direction to all involved in this health care process.

In implementing a Whole System approach, services are organised around the patient. All members of an integrated care team recognise they are interdependent and that action in one part of the system has an impact elsewhere. In order for this guidance to operate effectively, comprehensive integrated co-operation is required between the disciplines in the integrated care team. Adequate communication is required between members of the integrated care team and other relevant health and social care professionals in the community in order that patients experience services as seamless and the boundaries between service providers are not apparent. Multi professional training will help break down professional barriers and develop a culture of collaboration and understanding, steps to encourage/ emphasize the importance of such multi-disciplinary training need to be taken and the importance of communicating details of the integrated care discharge/transfer strategy amongst members of the care team needs to be affirmed in the guidance.

In terms of patient treatment and assessment, further clarity is required on the roles and responsibilities in this area as different aspects of review and assessment of the patient may fall under the expertise of different members of the multi-disciplinary team, notwithstanding the value of overall leadership of processes.

However, the level of detail provided in the initial stages of the document, laying down the context and detailing definitions of integrated care may be surplus to the detail required.

8. Is the content accurate?

Yes	✓
No	
No View	

Comments:

9. Is the content complete?

Yes	
No	✓
No View	

Comments:

The importance of communicating details of the integrated care discharge/transfer treatment plan, to the patient and their carer clearly and frequently throughout the process should be strongly emphasized in the guidance. A patient held record, including all details of their care plan is essential, in order that the patient is informed in the care pathway and is enabled to pass this information on to other members of the care team, particularly those in primary care.

The importance of clarifying patient expectations as soon as possible may need to be highlighted more strongly in the guidance. These may be very different from those of the practitioners.

Providing the patient (family or carers) with verbal and written information regarding their medication regime and any changes made to it, is an essential role of the pharmacist, where necessary, providing information and education regarding the use and monitoring of medication. Pharmacist involvement in the cognitive assessment to determine the patient's suitability for self-medication is essential and this assessment should be documented in the healthcare record. The guidance needs to recognize this role.

10. Are there any gaps that should be addressed or areas that are not adequately addressed?

Yes	✓
No	
No View	

Comments / Suggestions:

The guidance recommendation on the provision of patient information packs is very valuable. It may be useful to acknowledge the pharmacist as the co-ordinator of medicines management as a whole, as the key team member in the preparation of Information packs for discharge on medication management information, including instructions on administration, the management of side-effects, and storage. Information providing clarity on any medication changes/discontinuation could also be included in the information pack.

The pharmacist, in controlling overall medicines management, should through communication and information, remove apprehension and confusion around issues relating to the patients medicines, by providing comprehensive counselling and advice in this area to the patient and their carer. The importance of this role is highlighted by the fact that re-presentation to hospital is often associated with medication mismanagement.

11. Can you suggest ways in which the clarity / presentation of the document can be improved?

Yes	✓
No	
No View	

Comments:

Giving greater prominence to the 'The nine steps for effective discharge planning' within the document may lend the guidance more useable in a practice environment. Perhaps using appendices to locate some of the background information on integrated care would achieve this.

12. Can you identify opportunities for improvement in the document?

Yes	✓
No	
No View	

Comments:

With regard to the 'Audit/Checklist' section of the guidance, at certain points in the checklist it may be useful to suggest that the most appropriate member of the integrated care team be specifically designated certain tasks, assigning responsibility within a shared accountability structure.

13.In addition to this document, are there other support resources you would like to see available?

Yes	✓
No	
No View	

Suggestions: A standardised template for use at discharge/transfer to communicate all details pertaining to the patients' medication on discharge should be developed and used universally. This template should allow for the full communication of current medication list, discontinued medicines (since discharge), dose changes, additions etc.

The development and use of a standardised form/template would greatly reduce confusion and errors in patient medications at the interface of care settings.

14. Are there any other issues that you would like to raise?

General comments and suggestions are welcome:

This guidance provides a significant opportunity to improve patient safety in the discharge/transfer of care process. The PSI supports the implementation of a new code of practice in this area.

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2. How would you classify yourself?

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Other (please specify)	✓

3. Do you wish to be identified as the author of your response?

Yes	✓
No	